CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE

BOARD OF NURSING

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

APPLICATION FOR LICENSURE AS AN ADVANCED PRACTICE REGISTERED NURSE
INSTRUCTION SHEET

Follow instructions carefully.
You must answer *all* questions unless the instruction says to skip them.
Do not leave answers blank if the instruction says to enter them. If an answer is "none," enter *None.*
Incomplete applications will be rejected.

When to File APRN Application

- You must be concurrently applying for, or already hold, an active Registered Nurse (RN) license either in Delaware or one of these *compact states*:

  Arizona, Arkansas, Colorado, Delaware, Idaho, Iowa, Kentucky, Maine, Maryland, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Mexico, North Carolina, North Dakota, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Wisconsin

  For important information on how the Nurse Compact affects your Nursing license, see *Compact (Multi-State) Licensure* on the Board of Nursing website.

- You must have a:
  - Master's degree, ***or***
  - Post-basic program certificate in a clinical nursing specialty with nursing certification from a national certification body recognized by the Board.

- You must meet one of these requirements in the role and population focus for which you are applying:
  - Practice in the specialty of either 600 hours over the past two years or 1,500 hours over the past five years, ***or***
  - Graduation from the specialty program within the past two years.

- If you wish to be licensed to practice in more than one APRN role and/or population focus, you must file a separate application for each.

- To practice as an APRN in Delaware, you must have a collaborative agreement ***only if*** you have practiced as an APRN less than two years ***or*** fewer than 4,000 hours. See 24 *Del. C.* §1936.
  - If a collaborative agreement is required, you may *file this application* before you have one, but you are *not allowed to start practicing* in Delaware until your APRN license (or a temporary permit) has been issued ***and*** you have a collaborative agreement at ***each*** individual business/practice where you will be practicing.
  - You must maintain a collaborative agreement until you have practiced as an APRN for at least two years and at least 4,000 hours.

- If your application is not complete within one year of filing, it may be considered abandoned and discarded.

- If you hold a Delaware RN license, your APRN license will have the same expiration date and come up for renewal at the same time as your Delaware RN license. However, if you hold an RN license in another compact state, your APRN license will expire on 9/30 of odd years.

Requirements for *All* Applicants

The following are required of all APRN applicants unless otherwise stated.

☐ Submit completed, signed and notarized *Application for Licensure as an Advanced Practice Registered Nurse* form.
- **Follow instructions carefully. You must answer *all* questions unless the instruction says to skip them. Do not leave answers blank if the instruction says to enter them. If an answer is "none," enter *None.* *Incomplete applications will be rejected.***
- Read the AFFIDAVIT section and sign the application in front of a notary public. Forms that are unsigned or not notarized will be rejected.

☐ Enclose the ***non-refundable*** processing fee by check or money order made payable to "State of Delaware."
- If submitted without this processing fee, your application will be rejected.
- Even if your application is not approved, the processing fee will not be refunded.

☐ Unless you are applying for a Delaware RN *at the same time*, complete the *Authorization for Release of Information* form to request State of Delaware and Federal Bureau of Investigation criminal background checks. Follow the instructions on the form to arrange to be fingerprinted.
- You must meet this requirement *even if* you recently had a criminal background check done for another reason.
- Information or details on the State and Federal background report will be reviewed to determine whether you must submit any additional information or documents as part of the application process.

☐ Unless you are applying for a Delaware RN *at the same time*, enclose a copy of your driver's license or official identification card from the Division of Motor Vehicles.

☐ Arrange for the Board office to receive an official transcript sent *directly* from your APRN program to the Board office.

☐ Enclose a copy of your original certification notice or current re-certification card with your application.

☐ Complete the applicant section of the *Verification of National Certification* form. Send it to the organization that issued your national certification.
- There may be a fee.
- After completing the form, the organization must return the form *directly* to the Board office. Forms received from you will be rejected.

☐ Request a self-query from the National Practitioner Data Bank (NPDB) website at www.npdb.hrsa.gov. The self-query report will be mailed to your address. When you receive the report, submit the ***original report*** to the Board office.

☐ If you are required to have a collaborative agreement(s) to practice in Delaware, submit a *Collaborative Agreement* form for ***each*** individual business/practice where you will be practicing in Delaware. If you do *not* have a collaborative agreement when you file this application, you must obtain a collaborator and file a *Report of Collaborative Agreement Change* form ***before*** you begin to practice as an APRN in Delaware.
- You are required to have a collaborative agreement(s) ***only if*** you have practiced as an APRN less than two years ***or*** fewer than 4,000 hours. For example, if you are a new graduate APRN who has practiced almost two years, you must have a collaborative agreement even if you have already attained 4,000 or more hours.
- You must have a collaborative agreement at *each* business/practice where you will be practicing. For example, if you are employed by a hospital and by a primary care practice and you will be practicing as an APRN at both, you must complete a form for the hospital and a separate form for the primary care practice.
- If a business/practice has multiple Delaware locations where you will be practicing, you need only complete one form for the business/practice. You may use the main location of the business/practice as the address. For example, if you work for a primary care practice that has offices in two Delaware towns, complete only one form for the practice.

☐ If you have never been issued a United States Social Security Number (SSN), submit a *Request for Exemption from Social Security Number Requirement*.
The Privacy Act of 1974, Section 7, requires the following information to be given to all applicants: Applicants for any Delaware professional or occupational license, permit, registration or certificate (other than Gaming permits) are required to provide a U.S. SSN (29 *Del. C.* §8735(m)). The Division of Professional Regulation uses the SSN primarily to verify identity and safeguard personal information. It may also be used to enforce child support obligation (13 *Del. C.* §2216) and for other lawful purposes.

Temporary APRN Permit

If you wish to apply for a Temporary APRN Permit, see Temporary APRN Permit.

Requirements for Prescriptive Authority

To prescribe ***non-controlled*** substances in Delaware, you must have prescriptive authority as well as APRN licensure. The APRN application asks whether you are also applying for prescriptive authority. You may apply for prescriptive authority at the same time as you apply for APRN licensure or later on.

Prescriptive authority alone does ***not*** allow you to prescribe controlled substances in Delaware. See the **Important Information about Prescribing Controlled Substances** section below.

These are the requirements to receive prescriptive authority at the same time as your APRN license…

☐ Answer "yes" to Question 2. There is no additional fee to apply for prescriptive authority.

☐ Your APRN program official transcript must ***clearly*** show that you have completed academic courses in ***all*** of these:

- advanced health assessment
- diagnosis and management of problems within your clinical specialty
- advanced pathophysiology
- advanced pharmacology/pharmacotherapeutics

If the transcript doesn't ***clearly*** show this coursework, the Board office will contact you for further documentation.

☐ Use the following table to decide if you must submit documentation of continuing education (CE) ***in (or related to) advanced pharmacology and pharmacotherapeutics***. Acceptable documentation is the completion certificate you receive at the end of the educational activity. Documents such as copies of your course registration or letters/emails thanking you for registering are ***not*** acceptable proof that you completed the coursework.

IF you…	**THEN** you…
completed your APRN program within the two years before submitting this application	do *not* need to submit proof of any CE.
hold a current, unencumbered APRN license in another jurisdiction (state, U.S. territory or District of Columbia) and that license is ***clearly marked*** with prescriptive authority	submit • copy of the APRN license • documentation that you have completed at least 10 hours of CE in (or related to) advanced pharmacology and pharmacotherapeutics during the past two years.
• completed your APRN program more than two years before you submit this application, ***and*** • do **not** have prescriptive authority in another jurisdiction	submit documentation that you have completed at least 30 hours of CE in (or related to) advanced pharmacology and pharmacotherapeutics during the past two years.

Important Information about Controlled Substance Registrations

If you receive prescriptive authority, you are allowed to prescribe ***only non-controlled substances***. To prescribe controlled substances in Delaware, you must have ***all*** of the following:

- Delaware APRN license ***with*** prescriptive authority
- Delaware CSR

  Note: If you practice at more than one business/practice, you need only a single CSR to ***prescribe*** at all of the locations. However, every Delaware location where controlled substances are dispensed/stored must be covered by a CSR. If no other practitioner (e.g., physician), physician assistant or APRN holds a Delaware CSR for a location where you will ***store/dispense***, as well as prescribe, controlled substances, you must file for an additional CSR for the location.

- Federal DEA registration for Delaware (a DEA registration in another jurisdiction is not sufficient)

To apply for a CSR(s), see *Controlled Substances Registration – Advanced Practice Registered Nurses*. For Federal DEA registration, see DEA New Registration Applications.

Requirements for Independent Practice

If you are approved for independent practice, you are allowed to practice and prescribe

- outside the employment of an established health-care organization, health-care delivery system, physician, podiatrist, or practice group owned by a physician or podiatrist
- without a collaborative agreement

Your independent practice must be in an area substantially related to the population and focus of your APRN education and certification. You must file a separate application for each APRN role and population focus where you will be practicing independently.

You may apply for independent practice at the same time as your Delaware APRN license or later. However, ***before*** applying for independent practice, you must meet ***all*** of the following requirements for the role and population focus for which you are applying:

- Practice as an APRN for at least two years with a collaborative agreement, ***and***
- Practice as an APRN for at least 4,000 full-time clinical hours with a collaborative agreement, ***and***
- Completion of the clinical experience within five years before applying for independent practice.

See 24 *Del. C*. §1902 (k) and Section 8.17 in the Board's Rules and Regulations**.**

If you wish to apply for independent practice at the same time that you apply for an APRN license …

☐ Answer "yes" to Question 5. There is no additional fee to apply for independent practice at the same time as your APRN license.

☐ Submit a signed, completed *Application for Independent Practice as an Advanced Practice Registered Nurse*.

- Follow the instructions on the form.
- This requirement is in addition to all other requirements for APRN licensure.

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OFFICE USE ONLY
DDB_____
ID _____
Compact or DE RN

APPLICATION FOR LICENSURE AS AN ADVANCED PRACTICE REGISTERED NURSE

Follow instructions carefully.
You must answer *all* questions unless the instruction says to skip them.
Do not leave answers blank if the instruction says to enter them. If an answer is "none," enter *None.*
Incomplete applications will be rejected.

TYPE OF APPLICATION

1. Check your reason for filing this application: ☐ I am applying for an *initial* Delaware APRN license.
   ☐ I am reinstating a *lapsed* Delaware APRN license. Enter lapsed license number: **L** ___ - _____

2. Are you also applying for prescriptive authority at this time? Yes ☐ No ☐
   - **If you hold a current, unencumbered APRN license clearly marked with prescriptive authority, submit a copy of it.**
   - **In addition, the Instruction Sheet explains when to submit documentation of continuing education in (or related to) advanced pharmacology and pharmacotherapeutics.**

3. Select the status of your Registered Nurse license (check one):
   ☐ I am also filing a separate application for a Delaware RN license at this time.
   ☐ I already hold an active Delaware RN license. Enter license number: L1 - _____
   ☐ I hold an active ***compact RN license*** in _____. Enter license number: _____
   For information on compact licenses, see *Compact (Multi-State) Licensure*.

4. Select the APRN specialty for which you are applying. Check only ***one*** role.
   ☐ Certified Registered Nurse Anesthetist (CRNA)
   ☐ Certified Nurse Midwife
   ☐ Certified Nurse Practitioner (NP) – Check ***one*** population focus area in this role:
   ☐ Adult/Gerontological ☐ Family ☐ Neonatal ☐ Pediatric
   ☐ Psychiatric/Mental Health ☐ Women's Health/Gender-Related
   ☐ Clinical Nurse Specialist (CNS) – Check ***one*** population focus area in this role:
   ☐ Adult/Gerontological ☐ Family ☐ Neonatal ☐ Pediatric
   ☐ Psychiatric/Mental Health ☐ Women's Health/Gender-Related

   You must complete a separate application for each role/population focus for which you wish to be licensed.

5. At this time, do you wish to apply for independent practice in the specialty you checked in Question 4? Yes ☐ No ☐
   If yes, submit an *Application for Independent Practice as an Advanced Practice Registered Nurse* following instructions on the form.

IDENTIFYING AND CONTACT INFORMATION

6. Full Name: _____ _____ _____ _____
   Last First Middle Maiden

7. Other Names Used: None ☐ _____ _____ _____

8. Date of Birth (month/day/year): _____ Gender: Male ☐ Female ☐

9. Have you been issued a U.S. Social Security Number? Yes ☐ No ☐ **If yes, enter SSN:** _____
If no, you must file a *Request for Exemption from Social Security Number Requirement*.

10. Enter your *State or Jurisdiction of Residence*: _____ *Unless you are concurrently applying for a Delaware RN license*, **enclose a copy of your driver's license or an identification card issued by the Division of Motor Vehicles showing this state or jurisdiction as your residence.**

11. Mailing Address: _____

_____ _____ _____
City State Zip

12. Phone: _____ _____ Email: None ☐ _____
daytime evening or cell

EDUCATION

13. Enter the following information about the APRN program you completed:

School Name: _____

Program Name: _____

Address: _____

_____ _____ _____
City State/Country Zip/Postal Code

Entered Program (month/year): _____ Completed Program (month/year): _____

Degree Conferred: _____ Role and Population Focus: _____

Arrange for your program to send an official transcript *directly* to the Board office.

14. Do you have additional graduate degree education? Yes ☐ No ☐ If yes, enter the following information about *each* institution from which you hold a graduate degree. If no, skip to the **CERTIFICATION** section.

COLLEGE/UNIVERSITY NAME	DATES ATTENDED		DEGREE
	From	To	

CERTIFICATION

15. Have you been granted certification? Yes ☐ No ☐ If yes, continue with Question 16. If no, check the reason that you do not have certification, then skip to the **APRN PRACTICE** section:

☐ I am eligible for but have not yet taken the examination.

☐ I am not eligible to take the examination. Explain: _____

☐ I failed the examination. When? _____

☐ Other. Explain: _____

16. Enter the following information about your certification.

CERTIFICATION INFORMATION

National Certification Organization: _____

Certification Number: _____ Expiration Date: _____

Certification Granted by: Exam ☐ Waiver ☐

Has your national certification ever been suspended, revoked or otherwise disciplined? Yes ☐ No ☐ If yes, explain:

_____

Enclose copy of your current certification document. Also, complete the applicant section of the *Verification of National Certification* form and send it to the organization that issued your national certification.

APRN PRACTICE

17. Check the ***one*** item that *best* describes your APRN practice in the *role and population focus for which you are applying*:

    ☐ I have practiced at least 1,500 hours over the past five years ***or*** 600 hours in the past two years.

    ☐ I graduated from my APRN program within the past two years and I don't meet the practice requirement above. Skip to the **COLLABORATIVE AGREEMENT INFORMATION** section**.**

    ☐ Neither of the above applies to me. **Enclose a written explanation.**

18. Enter the following information about your practice ***in your role and population focus area*** over the past ***five*** *years*. ***Do not enter clinical experience from your APRN program and do not enter any RN practice.***

EMPLOYER	ADDRESS	EMPLOYMENT DATES	
		From	To

COLLABORATIVE AGREEMENT INFORMATION

19. Have you practiced as an APRN at least two years? Yes ☐ No ☐
    - **If no, you are required to have a collaborative agreement. Skip to Question 21.**
    - **If yes, continue with the next question.**

20. Have you practiced as an APRN at least 4,000 hours? Yes ☐ No ☐
    - **If no, you are required to have a collaborative agreement. Continue with the next question.**
    - **If yes, you are not required to have a collaborative agreement. Skip to the DISCLOSURES section.**

21. Do you have a collaborative agreement in Delaware? Yes ☐ No ☐
    - **If no, you must submit a *Report of Collaborative Agreement Change* form later on. You cannot *practice* as an APRN in Delaware until you have *both* a collaborative agreement *and* your APRN license (or temporary permit). Skip to the DISCLOSURES section.**
    - **If yes, continue with the next question.**

22. Complete the following information about ***each*** individual business/practice where you will be practicing in Delaware. Do not list multiple locations of the same business/practice. *If you need more room, enclose a separate sheet with the same information.*

DELAWARE BUSINESS/PRACTICE NAME	BUSINESS/PRACTICE ADDRESS

Submit a completed and signed *Collaborative Agreement* form from *each* business/practice where you will be practicing in Delaware.

23. Do you agree to report to the Board office any changes in the person, facility or healthcare system with which you have collaborative agreements? Yes ☐ No ☐

DISCLOSURES

Unless you are applying for a Delaware RN *at the same time*, complete the *Authorization for Release of Information* form to request State of Delaware and Federal Bureau of Investigation criminal background checks. Follow the instructions for fingerprinting.

24. Have you ever been denied Nursing licensure in Delaware or any other jurisdiction? Yes ☐ No ☐ If yes, where? _____ **Enclose a copy of the legal documents.**

25. Have any of your Nursing licenses ever been disciplined, including revocation, suspension, probation, voluntary surrender, limitation or letter of reprimand? Yes ☐ No ☐ If yes, where? _____ **Enclose a copy of the legal documents**.

    Request a self-query from the National Practitioner Data Bank (NPDB) website at www.npdb.hrsa.gov. The self-query report will be mailed to your address. When you receive the report, submit the *original report* to the Board office.

26. Are *any* of your Nursing licenses currently under investigation? Yes ☐ No ☐ If yes, where? _____ **Enclose a copy of the legal documents**.

27. Have you ever been declared judicially incompetent? Yes ☐ No ☐ If yes, explain: _____

    _____

28. Are you now, or have you *ever* been, dependent on the use of alcohol, stimulants, or habit-forming drugs? Yes ☐ No ☐ If yes, explain: _____

    _____

DUTY TO REPORT

29. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** obligation to file a written report with the Board of Medical Licensure and Discipline within 30 days if you have any reason to believe that a medical practitioner *other than yourself* is (or may be) guilty of unprofessional conduct as defined in 24 *Del. C.* §1731 OR that he/she is (or may be):
    - medically incompetent
    - mentally or physically unable to engage safely in the practice of medicine
    - excessively using or abusing drugs including alcohol.

    Have you read the provisions of 24 *Del. C.* §1730, 24 *Del. C.* §1731 and 24 *Del. C.* §1731A and do you understand your *duty to report?* Yes ☐ No ☐

30. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** obligation to make an immediate oral report to the Department of Services for Children, Youth and Their Families if you know of, or you suspect, child abuse or neglect under Chapter 9 of Title 16 and to follow up with any requested written reports.

    Have you read 16 *Del. C.* §903 and do you understand your *duty to report*? Yes ☐ No ☐

31. To obtain a license in Delaware, you must certify that you understand that you have a mandatory duty to report any unsafe nursing practice to the Board of Nursing and to report any unsafe practice conditions to the recognized legal authorities.

    Have you read Section 7.3.1.6 of the Board of Nursing's Rules and Regulations and do you understand your *duty to report*? Yes ☐ No ☐

If Board review of your application is required, the Board office must receive all of these items no later than 4:30 PM ten full working days before the Board's meeting date in order to ensure consideration of your application at the meeting:

- **Completed, signed and notarized application form**
- **Fee payment**
- **All required supporting documentation.**

Applications that are not complete within one year of filing may be considered abandoned and discarded. When your application is complete, allow 4-8 weeks to receive your permanent license (whether or not a temporary license has been issued).

AFFIDAVIT

The law regulating the practice of Nursing in Delaware, 24 *Del. C*. §1922 (a), "Grounds for Discipline," provides that the Board of Nursing may revoke or suspend any license to practice nursing, refuse a license or re-licensing or otherwise discipline a licensee upon proof that a licensee or former licensee is guilty of fraud or deceit in procuring or attempting to procure a license to practice nursing. The applicant, being duly sworn, says that he/she is the person referred to in the foregoing application for licensure as an advanced practical nurse in the State of Delaware, that he/she meets the requirements for licensure, that the statements therein contained are true and that he/she has read and understands this affidavit.

***Applicant Signature*:** _____ Date: _____

County of _____ State of _____

Sworn to before me and subscribed in my presence this _____day of _____ 2_____

Notary Public: _____

SEAL

My commission expires: _____

APPLICATIONS THAT ARE UNSIGNED, NOT NOTARIZED, INCOMPLETE OR SUBMITTED WITHOUT THE REQUIRED PROCESSING FEE WILL BE REJECTED

OFFICE USE ONLY

Prescriptive Authority

☐ Approved on: _____

☐ Not approved - reason: _____

Independent Practice

☐ Approved on: _____

☐ Not approved - reason: _____

By: _____

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COLLABORATIVE AGREEMENT

INSTRUCTIONS

A collaborative agreement is required for Advanced Practice Registered Nurse (APRN) practice in Delaware *only if* the APRN has practiced as an APRN less than two years *or* fewer than 4,000 hours.

- Submit a completed and signed *Collaborative Agreement* form from *each new or additional collaborator.*
- The APRN must sign the top box. The collaborator/designee at this business/practice must sign the **CERTIFICATION OF COLLABORATIVE AGREEMENT** below it.

BUSINESS/PRACTICE INFORMATION - *To be completed and signed by APRN*

1. APRN Name: _____ Delaware License: L ___ - _____

2. Business/Practice Name: _____

3. ***Location*** Address: _____
(If more than one location, enter main location. *No PO Box!)*

_____ DE _____ Business Phone: _____
City State Zip

4. Name of Collaborator at this Business/Practice: _____

5. Select the item that describes your collaborative agreement at this business/practice (check all that apply):
   - ☐ A - I have healthcare facility approved clinical privileges.
   - ☐ B - I have a healthcare facility approved job description.
   - ☐ C - I have a written agreement with a physician, podiatrist, or licensed Delaware healthcare delivery system.

6. Will you be prescribing controlled substances at any location of this business/practice? Yes ☐ No ☐

7. Do you agree to report to the Board office any changes in the person, facility or healthcare system with which you have a collaborative agreement? Yes ☐ No ☐

I affirm under penalty of perjury that the foregoing statements are true and complete to the best of my knowledge.

Signature of APRN: _____ Date: _____

CERTIFICATION OF COLLABORATIVE AGREEMENT - *To be completed and signed by collaborator/designee*

I certify that a process for consultation and referral of clients has been established with the APRN named above. I understand that this agreement remains in place until either the APRN or collaborating practitioner/health care system notifies the Delaware Board of Nursing in writing that the collaborative agreement is terminated.

Signature: _____ Date: _____

Print Name of Person Certifying to the Collaborative Agreement: _____

Are you a Delaware-licensed physician or podiatrist? Yes ☐ No ☐

- If yes, enter your Delaware License No: _____
- If no, enter title and healthcare system you represent: _____

Instructions for Requesting a Criminal Background Check

Both State of Delaware and Federal Bureau of Investigation criminal background checks are required.

Applicant Notification

Your fingerprints will be used to check the criminal history records of the Federal Bureau of Investigation (FBI). You have the opportunity to challenge the accuracy of the information contained in the FBI identification record. See Title 28, CFR 16.34 for the procedure to obtain a change, correction or update in the FBI record.

Locations

Kent County – Primary Facility
State Bureau of Identification
Blue Hen Mall & Corporate Center
655 S. Bay Rd. Suite 1B
Dover, DE 19901
Walk-ins accepted: Mon 8:30 am – 6:30 pm, Tue - Fri 8:30 am – 3:30 pm
Customer Service: (302) 739-2134

New Castle County - Satellite Facility
State Police Troop Two
100 LaGrange Ave
Newark, DE 19702
(between Rts. 72 and 896 on Rt. 40)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Sussex County – Satellite Facility
Thurman Adams State Service Center
546 S. Bedford Street, Rm. 202
Georgetown DE 19947
(across from DelDOT & Troop 4)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Applicants in Delaware

1. If you are using the New Castle County or Sussex County locations, call **(800) 464-HELP (4357)** to schedule an appointment. No appointments are needed at the Kent County location.

2. Take the completed *Authorization for Release of Information* form to one of the offices listed above with the fee of $65.00, to cover both the State of Delaware and Federal Bureau of Investigation criminal checks. Money orders and credit cards other than American Express are accepted at all locations. New Castle and Kent Counties accept cash; Sussex County does not accept cash. ***Personal checks are not accepted in any county.*** As fees are subject to change, contact the agency where you plan to submit your forms for current fees.

Applicants Not in Delaware (including Out-of-State or Outside the United States)

1. Your local police agency can fingerprint you. All types of fingerprint cards are accepted. Or, you may print a FD-258 fingerprint form available on the FBI website at www.fbi.gov – click *Services*, then *Identity History Summary Checks*, then scroll down to Option 1, Step 2, and click the link for *standard fingerprint form (FD-258)*. You may print the form on regular paper.

2. Your *Authorization for Release of Information* form and the fingerprint card must be complete. If identifying information is missing (such as name, date of birth, race, gender, etc.), your form will be returned.

3. ***Mail*** the *Authorization* form, fingerprint card, and *certified* check or money order (***personal checks are not accepted***) for $65.00 made payable to "Delaware State Police" to:

Delaware State Police
State Bureau of Identification (SBI)
PO Box 430
Dover, DE 19903-0430

DO NOT SEND THIS FORM OR FEE TO YOUR PROFESSION'S BOARD OFFICE.

DO NOT SEND THIS FORM OR FEE TO THE DIVISION OF PROFESSIONAL REGULATION.

⇨***ALLOW FOUR WEEKS FOR RECEIPT OF RESULTS.***

Revised 7/2017

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AUTHORIZATION FOR RELEASE OF INFORMATION

CRIMINAL HISTORY RECORD CHECK FOR PROFESSIONAL LICENSURE APPLICANTS

Please print or type all information in black ink.

Check the type of license for which you are applying:

- ☐ Adult Entertainment
- ☐ Charitable Gaming Vendor
- ☐ Chiropractic
- ☐ Dental
- ☐ Funeral
- ☐ Massage
- ☐ Medical (Physicians, Physician Assistants, Respiratory Care Practitioners, Eastern Medicine Practitioners, Acupuncture Practitioners, Genetic Counselors, Polysomnographers, Midwifery Practitioners (CM, CPM))
- ☐ Mental Health (LPCMH, LCDP, LMFT, LAPCMH, LAMFT)
- ☐ Nursing (RN, LPN, APRN)
- ☐ Nursing Home Administrator
- ☐ Occupational Therapy
- ☐ Optometry
- ☐ Pharmacy (includes key personnel of facilities licensed by Board of Pharmacy)
- ☐ Physical Therapy/Athletic Trainer
- ☐ Podiatry
- ☐ Psychology
- ☐ Real Estate Appraiser (includes Appraisal Management Company)
- ☐ Speech/Hearing
- ☐ Social Work
- ☐ Texas Hold'em Individual

Print your current full name:

_____ _____ _____ _____
Last Name First Name Middle Initial Suffix (e.g., Jr., Sr.)

Enter all other names you have used in the past (including, but not limited to, maiden name, former married names, alternative spellings):

1. _____
2. _____
3. _____
4. _____

As an applicant, I authorize release of any and all information that you have concerning my **CRIMINAL HISTORY RECORD INFORMATION**. I hereby release you, your organization, the State of Delaware and others from any liability or damage which may result from furnishing this information:

SIGNATURE OF PERSON PRINTED: _____ **Date**: _____

Phone: Home _____ Work _____

Mail the results of my criminal history request to:

Division of Professional Regulation
861 Silver Lake Boulevard, Suite 203
Dover DE 19904
SLC D420A

USE OF CRIMINAL HISTORY RECORD INFORMATION IS RESTRICTED BY LAW AND SHALL BE LIMITED TO THE PURPOSE FOR WHICH IT WAS GIVEN. MISUSE CONSTITUTES A CRIMINAL VIOLATION.

Revised 7/2017

CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
BOARD OF NURSING

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

VERIFICATION OF NATIONAL CERTIFICATION FOR ADVANCED PRACTICE NURSES

APPLICANT INFORMATION - to be completed by APRN applicant

Send to the national certifying organization for your advanced practice specialty.

1. Name: _____ _____ _____ Social Security Number: _____
   Last First Middle
2. Address: _____
   Street
   _____ _____ _____
   City State Zip
3. Phone: _____ Email: _____

As an applicant for APRN licensure in the State of Delaware, I authorize release of the requested information.

Applicant Signature: _____ Date: _____

CERTIFICATION – to be completed by national certifying organization

Return completed form *directly* to Board office address above.

1. Name of School/Program Applicant Attended: _____
2. Address: _____
   Street
   _____ _____ _____
   City State Zip
3. Entered Program (month/year): _____ Completed (month/year): _____
4. Was school/program approved? Yes ☐ No ☐ If yes, by what certifying body? _____
5. Was program an external degree? Yes ☐ No ☐
6. Type of Program: Certificate ☐ Baccalaureate ☐ MSN ☐ Area of Specialty: _____
7. Certification No.: _____ Effective Date: ☐ Exam _____ ☐ Waiver _____
   month/day/year month/day/year
8. Certificate Status: ☐ Active/Current _____ ☐ Lapsed/Delinquent _____ ☐ Inactive/Non-Practicing
   month/day/year month/day/year
9. Has disciplinary action been taken against this certificate ***or*** has it ever been voluntarily surrendered? Yes ☐ No ☐
   If yes, please explain on a separate sheet.

I certify that the information above is a true report for the nurse named above according to this agency's records.

Certifying Agency: _____

Person Completing Form: _____ Title: _____

SEAL

Signature: _____ Date: _____